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*Special Litigation Section - PHB
950 Pennsylvania Avenue, NW
Washington, DC 20530*

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BY ELECTRONIC AND U.S. MAIL

Gretchen W. Kraemer, Esq.
Assistant Attorney General
State of Iowa
Department of Justice
Hoover State Office Building, Second Floor
Des Moines, Iowa 50319

United States v. State of Iowa, Case No. 04 cv 636;
Glenwood Resource Center

Dear Ms. Kraemer:

As you know, on May 19 - 23, 2008, the Department of Justice toured the Glenwood Resource Center ("GRC") in order to assess the status of the State's compliance with the Iowa State Resource Center Plan ("SRC Plan") entered as an order of the court on November 24, 2004. We write to memorialize the findings of our tour. Attached to this letter is a compliance chart detailing our findings in each of the areas covered by the SRC Plan.¹ We also have included (in the chart's middle column) our expert consultants' assessments and technical assistance. Please note that this is primarily their work product, which we have copied into the chart simply for ease of reference and to facilitate the provision of technical assistance.

¹ On April 2, 2008, the court entered the parties' Joint Motion for Entry of Stipulation for Supplemental Relief. That Joint Motion extended the implementation of certain provisions of the SRC Plan to October 30, 2008 and extended the final termination of the court's oversight of this action to April 30, 2010. The Joint Motion also required that Plans of Corrections be developed for those areas of the SRC Plan that the State had failed to implement timely. These Plans of Correction were entered as orders of the court on July 25, 2008.

We wish to extend special appreciation to you, Field Operations officials Sally Titus and Karalyn Kuhns, Superintendent Tom Hoogestraat, and the GRC staff for their continued hospitality, professional conduct, and timely response to our document requests.

As you will see, the Compliance Chart shows that the State and GRC are in compliance with the majority of the requirements of the SRC Plan. There are still areas of the SRC Plan, however, that require further effort. At the conclusion of our May visit, the State indicated its intention to immediately begin addressing the areas of non-compliance with the SRC Plan that we had preliminarily identified. We continue to be appreciative of the State's willingness to work cooperatively with the Department to improve services at GRC. The purpose of this letter is provide a brief summary of the status of the State's and GRC's compliance with the SRC Plan.

As with our earlier compliance tours of GRC, we toured the facility with expert consultants in nursing (including physician, psychiatric, and nutritional management services), psychological and habilitation services, protection from harm, and community integration. Consistent with our pledge of transparency, we provided detailed exit briefings at the conclusions of our tours and shared our findings and concerns. We also shared our preliminary findings in separate meetings with State's counsel, officials, and Mr. Hoogestraat.

Protection from Harm - SRC Plan III

We found GRC in substantial compliance with most elements of the SRC Plan concerning protecting residents from harm: restraint usage (SRC Plan III.A); time-out procedures (SRC Plan III.B); abuse neglect and incident management (SRC Plan III.C); and quality assurance (SRC Plan III.D). For example, we found GRC had done exemplary work in ensuring that investigations of incidents are timely and thorough, that follow-up actions are implemented, and that staff are adequately trained in performing investigations.

The principal provisions of the SRC Plan concerning keeping residents safe from harm where GRC still needs to make improvements relate to training issues: ensuring staff receive competency-based training in restraint use (SRC Plan III.A.3(a)) and that staff receive abuse/neglect awareness training (SRC Plan III.C.1(a)-(c)). For example, a review of the training records of 14 staff members revealed that only four had taken part in annual abuse/neglect awareness training within the last year.

GRC's data, however, reported 97 percent compliance with annual abuse training. Records also showed that only 53 percent of staff were compliant with annual MANDT training regarding restraint procedures. Thus, GRC needs to improve its training efforts to achieve compliance with the SRC.

Further, regarding restraint practices, it does not appear that the threshold of three restraints in four weeks systematically triggers a review of the behavioral treatment individuals receive, as reflected in the BSP (SRC Plan III.A.6). This appears to be, in part, an issue of incomplete documentation. In order to achieve compliance, however, the facility must demonstrate that, for each instance in which this trigger was met, treatment teams undertook substantive discussions of the adequacy of the behavior plan and documented the results of those discussions.

Integrated Protections, Services, Treatments, Supports
and Psychological and Communication Services -
SRC Plan IV, VII and XII

With regard to development of integrated, individual support plans ("ISPs") and psychological, behavioral and habilitation services, GRC continues to expend much effort to improve services. The assessment and interdisciplinary processes have improved. Additional therapists are providing substantially increased level of psychotherapy services, both on individual and group levels. Further, all required components of behavior plans are present and program integrity checks document implementation of behavioral plans. Support plans have also improved with respect to facilitating choice, enhancing independence, and supporting individuals' self-determination.

Despite these positive measures, key deficiencies remain in providing adequate psychological and habilitative services to residents. For example, while we observed some improvement in interdisciplinary team functioning, too often action plans and the ISPs were not revised to implement conclusions reached by interdisciplinary teams and to address relevant clinical data (SRC Plan III.A.(6)). Some ISPs also continue to lack appropriate emphasis on individuals' priority needs (SRC Plan IV.B.2.(b)). Interventions, strategies, and supports in the ISPs are increasingly - though not universally - practical, functional, coordinated, and integrated (SRC Plan IV.B.2.(f)). However, continued vigilance on providing adequate active treatment is needed and some ISPs are still inadequate with respect to the amount of active treatment (SRC Plan IV.B.2.(f)).

Data analysis and characterization of progress occurring in the context of Monthly Integrated Reviews ("MIRs") are improved. However, additional efforts are needed to ensure that the process by which the team analyzes data and characterizes progress are consistent (SRC Plan IV.B.5). Behavior data are reviewed and progress is characterized monthly. For example, behavior data review occurs in a variety of contexts (e.g., MIRs, psychiatric consults, BMC Data Reviews). However, MIR minutes continue to yield examples of failure to look at longer-term trends and miss the "big picture" of a resident's progress (SRC Plan VII.3.(b)). Similarly, there is insufficient documentation of GRC responding to significant events (e.g., behavioral events, injury). For example, in approximately 25 percent of these type of instances reviewed during our tour, team meeting notes failed to explicitly mention whether behavioral reviews and/or treatment revisions were considered or undertaken (SRC Plan VII.3.(b)).

Continued emphasis on ensuring timely revisions to interventions in response to behavioral crises or lack of progress is also needed (SRC Plan VII.11). However, the quality assurance, monitoring, feedback and peer review systems that the facility has designed and implemented have the potential to systematically address these concerns as well as improve the quality of interdisciplinary team functioning, though these systems are not fully mature.

As we emphasized during our exit conference in May, communication training continues to be a serious deficit at the facility (SRC Plan XII). The absence of effective communication training is undermining efforts to offer individuals choices and to honor their preferences. Further, a lack of effective communication training undermines efforts to address individuals' challenging behaviors that serve a communicative function. This has been a long-standing issue that we have repeatedly identified to the staff of GRC. The failure of the facility to respond to long-standing deficiencies in communication training suggests that the facility has not yet developed the administrative capacity to correct known problems on a timely basis, which is concerning.

The facility is virtually at the beginning of the process with respect to instituting a system for creating, implementing, and monitoring communication training programs. Accomplishing this will require strong and effective leadership to foster a process of interdisciplinary collaboration that adequately addresses residents' needs.

Medical, Psychiatric, Neurologic and Nursing Care -
SRC Plan V, VI, VIII, IX, X

When we visited GRC in May, medical services were in transition. A new medical director had just finished her orientation to the facility. However, there had been positive developments in medical services. When we visited the daily morning meetings of medical and nursing staff, we found these discussions to be much improved over previous visits. There also had been other developments in this area. For example, medical service staff had developed and implemented an instrument for physician peer review (SRC Plan - V.A.1). The peer review will be conducted monthly and discussed at the Medical Peer Review Committee quarterly. However, as this system was only recently implemented by the time of our May tour, there was not yet indication that the issues identified by the peer reviews were being addressed. GRC staff informed us that the data from the physician peer reviews will be analyzed for trends and any needed plans of corrections will be developed and implemented.

While there had been some improvement in the quality of physicians' notes, this improvement was not sufficiently consistent. For example, physicians' assessments of individuals prior to a hospitalization were at times not adequate (SRC Plan - V.A.1(a-f)). In addition, some of the physicians' assessments that were conducted when an individual returned from the hospital focused more on the treatments that were provided at the hospital and lacked an actual physical assessment of the individual's status at the time he or she returned to GRC.

As part of our assessment of nursing care at GRC, we reviewed the records of ten individuals who were transferred to community hospitals due to acute changes in their health. Unfortunately, we found that nursing documentation regarding these events was inadequate (SRC Plan - X.3). For example, a number of nursing assessments only note "PNM [physical and nutritional management] Event" or "Condition Change" without providing a description of the event or condition change; there were inadequate nursing assessments regarding individuals' transfer to a hospital; and there were inadequate assessments of individuals when they returned from a hospital or infirmary visit.

GRC's data regarding nursing documentation showed a high rate of compliance that our review suggests is not correct (SRC Plan - X.4). GRC must work to ensure that nurses conducting the peer reviews understand the standards of nursing practice that they are reviewing, as nursing has made little progress regarding

the assessment of residents' clinical needs. Further, the nursing department still needs to develop and implement an effective system for critically reviewing the timeliness of assessments and the notification of the physician of an individual's status change. In fact, the GRC nursing department still needs to provide on-going training to nursing regarding assessments and timely notification of physicians for changes in status. In addition, there needs to be a regular review of the treatment plans for individuals with infectious diseases to ensure that objectives and intervention are appropriate and are actually being implemented (SRC Plan - X.1).

GRC has done a commendable job in maintaining compliance with the requirements of the SRC plan regarding neurological and psychiatric care and services (SRC Plan - VI and IX).

Physical and Nutritional Management - (SRC Plan XI)

As you are aware, a significant issue over time at GRC has been the facility's inability to adequately and safely meet the physical and nutritional management needs of residents. Thus, the facility remains out of compliance with critical provisions of the SRC Plan addressing PNM services (SRC Plan - Section XI). Since our September 2007 tour, GRC has taken the positive step of creating a single, interdisciplinary PNM team. GRC had also put together a basic framework for a PNM Manual. However, additional work will be needed on the manual as the PNM system is further implemented.

Although problematic issues existed with the PNM system in place at the time of our review, the PNM team was aware of these issues and was able to clearly articulate plans for corrective actions. This is a significant improvement from our September 2007 tour.

Given the number of high-risk individuals at GRC, the clinical staffing at GRC is an issue (SRC Plan - Section XI.A). While a PNM team exists, there is no formal PNM Department in place. All of the clinicians on the team have other duties aside from their work with the individuals at risk. In order to provide adequate services to this population, GRC might want to consider making PNM a formal department, staffed with an appropriate number of clinical professionals and clerical assistance.

From our review of high-risk individuals, we found that nursing staff assessments had identified individuals' PNM "triggers" (i.e., events indicating a potential PNM issue for a

resident, such as coughing during a meal). However, on our tour we noticed that a number of residents' triggers that had occurred had not been documented on the residents' Daily Activity Records ("DAR" - a tool GRC uses to evaluate individuals' progress. (SRC Plan - Section XI.A.2). Consequently, the PNM nurse and the PNM team were not alerted to conduct needed assessments. Direct support staff were also interpreting the cause of the triggers, and this is outside the scope of their responsibility. Thus, the accuracy of the monitoring of individuals at risk for PNM issues is not consistent and therefore unreliable. Without reliable data, significant PNM symptoms of residents are going unnoticed and unaddressed. The lack of consistent trigger identification and documentation continues to place individuals at risk for harm.

Further, it was difficult to determine if the PNM team actually reviewed an individual's overall PNM plan and a resident's status in a timely and adequate manner to determine if modifications to a resident's PNM plan were needed (SRC Plan - Section XI.A.2). While the PNM team meets weekly, it often appeared that the PNM team would wait for this meeting to review and address significant PNM issues. Waiting a week for a clinical review of a critically high-risk individual is not adequate. The PNM team needs to immediately respond to these type of issues.

While we found appropriate clinical justification for residents' feeding and positioning plans, staff did not consistently utilize such clinical information in determining the adequacy of, or need for PNM modifications (SRC Plan - Section XI.A.2-3). Also, key PNM information is not included in the electronic medical record. This poses a significant clinical barrier to being able to review triggers and interventions in a timely manner. In addition, nursing has not implemented adequate procedures for monitoring and documenting lung sounds for high-risk individuals.

However, the DAR recording done by staff is not consistent. Thus, evaluating progress or lack of progress based on the DAR data could be erroneous. Therefore, the current system at GRC does not adequately represent an individual's clinical progress and thus, the system continues to be reactive to issues involving residents' health rather than pro-active and attempting to ameliorate issues before they become serious threats to residents (SRC Plan - Section XI.A.7).

Further, we observed that staff in the residents' houses did not consistently implement individuals' meal plans as written.

We also noted staff failing to respond adequately to residents who began coughing during the meals. Additionally, while touring the houses, we found a number of residents' beds that were not at the incline prescribed in the residents' PNM plans (SRC Plan - Section XI.A.3). While GRC's compliance data indicates that PNM plans are fully and consistently implemented, our observations call these data into question. We also remain concerned that staff who "float" between residences are not adequately trained to assist high risk individuals with meals (SRC Plan - Section XI.A.5).

In sum, the lack of adequate implementation and evaluation of the individuals' PNM plans is a major issue for GRC and negatively affects GRC ability to comply with the SRC Plan (SRC Plan - Section XI.A.6-7-8).

Most Integrated Setting - SRC Plan XIII

GRC and the State are in compliance with the great majority of the SRC's requirements to serve residents in the most integrated setting appropriate to their needs. GRC continues to take proactive steps to encourage and assist individuals served and their guardians to access community services in the most integrated settings appropriate to their needs. For example, GRC has: 1) worked with families to attend a provider fair in the community; 2) continued to work on committees whose efforts help to build community capacity; 3) continued to expand the work of the mental health services to ensure that individuals who are transitioned into the community and require such services are provided them; and 4) worked with community providers, to implement a grant designed to develop additional community supports and resources for children.

However, there are significant issues regarding the State's quality assurance program concerning community providers. The system is still fragmented, and cannot yet ensure adequate reviews of provider agencies. During our latest review, the State provided us copies of a Notice of Intended Action to revise the State's regulations regarding incident reporting. Unfortunately, the revisions do not address concerns we had previously raised, such as the inadequacy of categories of incidents that need to be reported to State officials and delays in reporting incidents.

Also, it was unclear how the State is using information obtained through the incident management system to improve community services and to prevent the future recurrences of similar incidents. It does not appear that such information is

systematically and regularly reviewed to identify and address any problematic trends. An adequate incident management system is key to identifying problems occurring on an individual, program, and systemic level, and most importantly, to identifying and correcting problematic areas and issues on a timely basis. The current quality assurance program for community providers does not have such a system.

Further, the efforts of GRC to assist people in moving to the community continue to be stymied by the lack of community capacity (SRC Plan - XIV.A.1). However, the State has applied for a grant from the Centers for Medicare and Medicaid Services ("CMS") that could assist the State in developing addition services and supports. As we have previously stated, without the State's help to expand community capacity and fill the gaps in services available in the community, individuals will continue to live in more restrictive settings than necessary and will be waiting for community options appropriate to meet their needs for much longer than they should.

If you have any questions or concerns, please do not hesitate to contact either me, at (202) 514-0195, or the attorneys assigned to this matter, Benjamin O. Tayloe, Jr. at (202) 514-8103, Gregory Gonzalez at (202) 305-2941, or Verlin Deerinwater at (202) 514-6260.

Sincerely,



Shanetta Y. Cutlar
Chief
Special Litigation Section